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January 3, 2011

Ms. Christine Baker
Executive Officer
California Commission on Health and Safety and Workers' Compensation
1515 Clay Street, Room 901
Oakland, CA 94612

RE: CHSWC Draft Liens Report (December 16, 2010)

Dear Ms. Baker:

On behalf of my client, STOPS Enterprises LLC, a leading provider of transportation, translation and interpretation services for the workers' compensation industry, we thank you for giving us the opportunity to provide our comments pertaining to the Commission on Health and Safety and Workers' Compensation's Draft Liens Report issued for public comment on December 16, 2010.

We commend the Commission and its staff for the thorough study of the Lien issue and the recommendations provided in its report to resolve the excess amount of liens filed each year that are clogging our state's workers' compensation system. The frequency of liens filed result in tremendous delays in the resolution of claims for injured workers, employers, insurers and providers.

In the transportation, translation and interpretation services industry, there is a growing concern for the lack of qualified certified Medical and Administrative Interpreters in the W/C system. This is due to the fact that the State Personnel Board has not conducted testing for Medical and Administrative Interpreters for several years. The State Judicial Council is the only one testing, and that is for Court Interpreters. This exam covers issues outside and around the qualifications necessary for the Medical and Administrative Interpreter testing. This test requires knowledge of the medical and administrative functions of the workers' compensation system. The Court Interpreter is more expensive to administer than the testing necessary for the Medical and Administrative testing.

The shortage of qualified and certified Medical and Administrative Interpreters causes delays in medical treatment for the injured worker, thereby causing delays in return-to-work for both the worker and the employer. Delays in return to work also generate higher costs to the employer due to limited access of qualified and certified interpreters.

By enabling a licensed private third party to conduct the testing for Medical and Administrative Interpreters, delays in the selection of qualified interpreters will be

reduced along with the costs to the state.

Additionally, we would like to offer the following comments for your consideration to be achieved either through legislation or regulation:

- Authorize the use of interpreters from other states so long as the interpreters are certified in their current state. This will increase the number of available interpreters and reduce access issues.
- Recognize the use of Federal Court Interpreters for state matters and workers' compensation. This will also increase the number of available interpreters and increase competition.
- Authorize private certification companies to certify interpreters. This will facilitate the increase of interpreters and competition.
- Modify the fee schedules based upon the type of language:
 - Medical Spanish
 - Medical Non-Spanish
 - Admin Spanish
 - Admin Non-Spanish
 - Court Certified Spanish
 - Court Certified Non-Spanish

We will be happy to provide any additional information or documentation on the suggestions outlined above. Our goal as the industry providers of transportation, translation and interpretation services is to serve as the resource to the Commission on behalf of our industry and to assist the Commission in its efforts to formalize its report recommendations.

Thank you once again for an excellent study on the lien issue. The Commission's study accurately and thoroughly reflects the magnitude of the amount of liens filed in California's workers' compensation system.

Respectfully,

Lori C. Kammerer
Kammerer & Company on behalf of
STOPS Enterprises LLC

January 3, 2011

Christine Baker, Executive Office
Commission on Health & Safety & Workers' Compensation
1515 Clay Street, Room 901
Oakland, CA 94612

Re: "Draft Liens Report"

Dear Ms. Baker:

On behalf of Pacific Compensation Insurance Company, we appreciate the opportunity to comment on the "Draft Liens Report". The comprehensiveness of this Draft Report is of great value to the workers' compensation community. All stakeholders should acknowledge our responsibility for this problem and our obligation to share in its resolution.

I. Introduction

The Executive Summary of the Draft Report begins with the statement, "Liens are both a cause and a result of serious distress in the California workers' compensation system." Liens, however, have been authorized since the Boynton Act, and while venerable does not necessarily mean valuable, it still must be questioned whether the current debate over liens should focus more on cause rather than effect. In other words, the seeds of the current dysfunction in this system were sown in 2003-04 and the rough transition required by AB 227 (Vargas), SB 228 (Alarcon) and SB 899 (Poochigian). For example, reinstating a lien filing fee¹ may prove palliative for the Appeals Board, but not curative of the med-legal process. The need for a revised and comprehensible Official Medical Fee Schedule touches on many issues well beyond lien filings, and yet even bringing the current fee schedule up to date seems beyond the administrative process.

This is not to suggest that the recommendations in the Draft Report do not warrant full consideration, but rather to suggest that substantive changes are now in order to fully realize the system that the reforms of 2003-04 were designed to create. Reforming the process by which billing disputes from service providers are resolved is an integral part of what should be a larger process.

¹ It should be noted that the visceral reaction by payers and lien claimants – albeit for different reasons – to reinstating the lien filing fee could be addressed (but not resolved) by making this an awardable cost at the close of the disposition of the lien dispute. In other words, rather than incurring the expense of processing the fee make it a cost awarded to the successful party to the dispute. While it can be argued that there are collection issues, the ability to file liens can be made dependent on the lien claimant paying its obligations and, conversely, the payer also paying its obligations.

In order to do this, the Commission should consider looking to other states, and to other benefit delivery systems, to ascertain whether changes can be made that would provide the necessary forum at the Division of Workers' Compensation (DWC) for disputes to be resolved while also providing the necessary framework for payers to resolve these disputes internally. This should include a review of a range of services required of healthcare service plans and health insurers under the Health & Safety and Insurance Codes as well as an examination of how other states address the multiple and interrelated issues of treatment authorization, billing and payment obligations, physician compensation, claims closures, and compensability determinations. While the "lien" is considered an albatross around the neck of California's system, the underlying disputes between payer and provider – regardless of the services – exist across state boundaries and across reimbursement systems.

Ultimately, we cannot have a workers' compensation system that fundamentally embraces an adversarial role with the physicians upon whom so much is dependent. Furthermore, we have to recognize that the practice of occupational medicine in virtually every state, and especially in California, requires time and effort beyond treatment that is far more time consuming and expensive than is the case with non-occupational healthcare. Essentially shifting the burden of bill review and coding to the physician should not be considered a viable option any more than it is in any other healthcare delivery system. With that recognition, however, comes the concomitant obligation on the part of the provider community to recognize that the onus of utilization review can be lessened by approaching requests for authorization differently than buying a pair of Nike's ("Just Do It") and that while workers' compensation is frequently referred to as the last bastion of fee for service medicine, it nonetheless is clearly supposed to be evidence based medicine.

This, in turn, leads us to the Appeals Board. One of the potentially unintended consequences of SB 899 was the significant increase in the need to utilize more formal concepts of evidence in disputes regarding both disability and the appropriateness of medical treatment. While judges are accustomed to deal with medical evidence in the civil courts, and there is a "substantial evidence" requirement within the Appeals Board, the current med-legal process does not necessarily lend itself to present evidence in its best evidentiary light². Consideration should be given to fundamentally changing the AME/QME process – and indeed eliminating it in its entirety - to assure that workers' compensation ALJs can be presented the best evidence in a relatively straightforward justiciable fashion on issues that are central to the prompt delivery of benefits. Those issues do not include resolving billing disputes.

² Labor Code §§ 5708 and 5709 should be amended to reflect the broader expression of Legislative intent in Section 4600 that the system is only to provide medical treatment that is consistent with the medical treatment utilization schedule and general principles of evidence based medicine.

Billing disputes are, in many respects, "paper" disputes involving primarily three issues: authorization, fee schedule application (OMFS versus contract rate³) and coding of the services provided. None of these issues should find their way to a workers' compensation ALJ, as the Commission Draft Report suggests. How these disputes are triaged and ultimately resolved, however, is an issue that requires a broader treatment than that in the Draft Report. Indeed, if the objective is to secure prompt payment and provide an expeditious, cost effective method to address utilization review and bill review issues, the primary focus of such changes should be at the plan (HCO, MPN, or Network) level and not with either the DWC or WCAB.

II.

The Primary Forum for Resolution of Disputes Should Be the Plan, Not the WCAB

Recommendation #6 of the Draft Report provides for the establishment of an administrative dispute mechanism to address billing disputes. While appropriate as part of an overall revision of the dispute resolution process for medical disputes, the recommendation is both too limited and fails to address broader dispute resolution processes that have been implemented in California for group health disputes and in other states for workers' compensation.

Health & Safety Code § 1367(h) provides, in part:

"All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted."

This mechanism is required to be made available to network and out of network providers. [Health & Safety Code §§ 1367(h)(1) and 1367(h)(2)]

The Department of Managed Health Care (DMHC) maintains a dispute resolution process to hear appeals from decisions made by plans.

This concept can and should be applied to workers' compensation networks, whether an MPN, HCO or a network that is formed with application of those statutory schemes. For example, the State of Oregon requires that a workers' compensation Managed Care Organization (MCO)

³ The Commission should consider either amending Labor Code § 5304 to allow the Appeals Board to adjudicate contract reimbursement issues or, conversely, if the Appeals Board does not have jurisdiction then it should be clarified that the Board cannot authorize a lien under Labor Code § 4903(b). In other words, how can the WCALJ adjudicate a lien over a contract rate when § 5304 says the Board has no jurisdiction?

“Provides adequate methods of peer review, service utilization review, quality assurance, contract review and dispute resolution to ensure appropriate treatment or to prevent inappropriate or excessive treatment, to exclude from participation in the plan those individuals who violate these treatment standards and to provide for the resolution of such medical disputes as the director considers appropriate. A majority of the members of each peer review, quality assurance, service utilization and contract review committee shall be physicians licensed to practice medicine by the Oregon Medical Board.” [ORS § 656.260(4)(d)]⁴

This dispute resolution process must be exhausted before an appeal to the Workers’ Compensation Division [ORS §§ 656.260(14); 656.248(12)]. (See also OAR §§ 436-009-0008 and 436-015-0110) This process is on a tight timeframe, the failure of which to follow authorizes the Director to reject the administrative appeal.

It is clear from the statutory framework of MPNs (Labor Code §§ 4616 et seq.) that there were a number of policy decisions made that are today proving less than optimal. The first is the issue of network management, including the goal that a set percentage of physicians be non-occupational providers. [Labor Code § 4616(a)] As the Draft Report correctly notes, the issue of whether a physician is within an MPN is a considerable source of conflict in the system – and is clearly an unintended consequence. It is also clear that prior efforts to address the formation of networks, embodied in Labor Code § 4609, are not as effective as originally intended. [See also: 8 CCR § 9767.3(d)(8)(C)]

To address this issue, several points need to be raised. The first is the various notice requirements required to implement an MPN. These requirements are not only labyrinthine, but also serve as a template to wrest medical treatment from the MPN and, more often than not, placed into the hands of a physician recommended by an applicant attorney. These multiple notices do not serve the employer or employee well.⁵ While the number of liens filed by MPN network providers appears small from the research conducted in the Draft Report, it is the issue of authorization that is the flash point in this discussion, not whether MPN network providers are being promptly and correctly compensated.

⁴ Some, but not all, of these requirements are imposed upon Health Care Organizations (HCOs) in California. (Labor Code §§ 4600.3, 4600.5) The HCO, added in the 1993 comprehensive reforms [AB 110 (Peace and Brulte)] is more in line with managed care reforms in most other states (the primary exception being Texas). Because of its complex rules trying to link employer sponsored health benefits with duration of control of medical treatment under the HCO, the HCO mechanism continues to be under utilized in California’s workers’ compensation system. Consideration should be given, especially with the ongoing implementation of the Affordable Care Act, to rethinking this mechanism for healthcare delivery and make it more viable in the marketplace, if for no other reason than the incentives the 1993 act were intended to create are far less important following the signing of the ACA by President Obama.

⁵ We are aware that the Commission is undertaking a review of benefit notices and would commend it to consider a more practical system of notices for MPNs. This is one area where the efficacy of reform falls disproportionately on self-insured employers who, being the MPN, have far less notice requirements than do insurers on policy anniversary dates.

Second, the purpose behind certifying the payer, rather than the network, was to provide maximum flexibility for payers to determine how best to meet their obligations under Labor Code § 4600. This, in and of itself, is a noble goal. It is, however, also a goal that to some degree is thwarted by the realities of network management. If the Commission were to study more fully the scope of dispute resolution in the Health & Safety Code, or to examine the practice and outcomes in the Oregon system, what would come from that is the concept that out of network providers should be equally obligated to utilize the dispute resolution resources of the MPN (payer). Part of the re-examination of the current state of MPNs should, therefore, be to place upon the MPN (not the MPN network) the option of creating a dispute resolution mechanism for disputes along the lines of what is currently set forth in the Health & Safety Code or in Oregon and, since the MPN is the ultimate payer, require *any* provider, regardless of whether they are in the MPN network, to exhaust those procedures before asking for a resolution before the DWC.⁶ The advantage to such a discretionary system is that the marketplace would provide the incentive to try to eliminate administrative disputes.

While the DWC has the authority to authorize MPNs to adopt such a procedure, there is a question as to whether contract provisions would be enforceable absent legislative sanction. An analogous circumstance is with pharmacy benefit management contracts authorized by Labor Code § 4600.2. While the payer community has made substantial use of pharmacy benefit management arrangements, it is an open question as to whether these arrangements would withstand judicial scrutiny absent the enabling regulations from the DWC. Thus, even though the MPN regulations could be amended to address a number of issues in the Draft Report, absent statutory change the question remains whether the WCALJs will uniformly enforce such regulations, especially in light of the AME/QME process.⁷

Such a requirement would not only significantly curtail practice on a “lien” basis but also raise the issue of whether a lien at all should be allowable.⁸

Third, while the Draft Report recommends billing and paying at the Official Medical Fee Schedule (OMFS) rate, this inevitably requires a serious discussion of how to administer a fee schedule that will be adequate on a timely basis?⁹ Clearly, the issue of whether to

⁶ This should also be applicable to HCOs under the “covered life” concept rather than the payer concept embodied in the MPN.

⁷ Former Insurance Commissioner Steve Poizner noted the need of carriers to utilize PBMs even though implementing regulations have not been promulgated. This observation was made without empirical support and ignored the significant use of PBMs in the workers’ compensation system by insurers even before passage of SB 899.

⁸ The Commission should ask itself the ultimate question – whether the concept of a “lien” should even be continued if a fair and adequate procedure can be developed to resolve disputes. The reason, in part, there are so few liens outside of California is that California is unique in providing such an expansive use of liens. We would recommend that if the appropriate internal dispute resolution process and administrative review were established, then providers should have no lien rights – liens being reserved for EDD, group health, and health facilities liens along the lines of subrogation rights.

⁹ While amendments to Labor Code § 5307.6 were intended to address the issues brought forth in Gould v. Workers' Comp. Appeals Bd. (1992) 4 Cal.App.4th 1059, 6 Cal.Rptr.2d 228, that discussion relates only to medical-legal expenses and not expenses under the OMFS. If the OMFS is to establish the

implement an RBRVS – based schedule and its corresponding issues of conversion factors continues to vex the DWC. Until that core issue is resolved, we are left with a series of ineffective provisions in the Labor Code to address network management (Labor Code § 4609) and the ability to apply contract rates (Labor Code § 5307.11).

Perhaps, the issue should be whether to make certain a provider, and the DWC, fully understand the rates of compensation for services rather than mandating that all fees are paid in accordance with the OMFS? This level of flexibility would be applicable only to situations where a contract rate was in place and not where there is treatment outside the network. Nevertheless, consideration should be given to Oregon provisions that require fee discount agreements to be filed with the regulatory agency and clearly demonstrate the consent of the provider to the discounted rates. (See: OAR § 436-009-0015) While such provisions may not affect a demonstrable reduction in lien filings, it would make network formation more efficacious and, combined with a viable internal dispute resolution mechanism, allow for a more expeditious resolution of fee disputes.

The role of the DWC and WCAB in the resolution of fee disputes should be limited. From a procedural standpoint, the DWC should assume a role similar to the Workers' Compensation Division (WCD) in the Oregon system and provide review only once an internal process by the claims payer, if one exists, is exhausted. From that limited review, the Appeals Board, and not individual WCALJs, should be empowered to conduct a "paper review" of the dispute where no new evidence is admissible and a decision is made on the record without the requirement that an evidentiary hearing be held (Labor Code § 5907). From there, consistent with the requirement of the California Constitution, review by the appellate courts will be guaranteed. The point, however, is to require an exhaustion of contract and administrative remedies before engaging the Appeals Board. Such a structure would apply regardless of whether the provider is part of a network and would allow the DWC to summarily reject any application for payment by a provider that was not first presented to a payer and went through the payer's bill review process.

Such a process needs to be established and enforced without equivocation. Any structure that allows evidence to be taken after the initial contractual and administrative processes are exhausted will only add more costs and more delays to the system.

III.

Interpreter Services Should be Considered a Medical Benefit

The Draft Report identifies critical issues regarding both photocopying and interpreter services. These services should be subject to a fee schedule and the administration of that schedule should be along the lines described in the Draft Report. As it relates to interpreter services, an additional consideration should be noted. While not expressly

rate for provider reimbursement, then it will have to meet the constitutional standards of providing a fair rate of return and if not periodically revised will be subject to scrutiny. [See: Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d 805 , 258 Cal.Rptr. 161; 771 P.2d 1247]

delineated as a medical benefit in the Labor Code¹⁰ it is difficult to argue that the provision of necessary medical treatment can be accomplished in accordance with the goals of the workers' compensation system if the injured worker cannot understand his or her doctor. Consequently, interpreter services should be considered a medical benefit – and as such be required to be provided by an MPN, HCO, or informal network.

Health & Safety Code § 1367.04 sets forth the requirements imposed on healthcare service plans to provide interpreter services. Similar obligations should be imposed on workers' compensation networks. Such a requirement would allow for necessary interpreter services to be provided as part of medical treatment without subjecting the payer to the frictional costs of dealing with contract interpreters who are providing services on a lien basis. Such services would be treated as other provider services, be subject to an internal dispute process, and allow for a consistent and appropriate use of such essential services.

IV. Conclusion

As previously noted, the question before the Commission is how to balance the need to address the resolution of causes of the current lien problems as opposed to their effects. The Draft Report leans more towards resolving effects rather than causes. This is certainly an acceptable direction and one that will meet with much support within the community. A better system, however, is more dependent on addressing structural issues that have emerged since 2002-03 and resolving them to make a fundamentally better workers' compensation system. As the Commission moves towards finalizing this report, additional issues will be noted, including whether the estimates of cost savings are realistic if more substantive changes are not implemented.¹¹

The Boynton Act is nearing its centennial. The delivery of healthcare has changed radically since then. It is time to acknowledge that the lien concept may no longer be applicable to a number of provider services and the elimination of lien rights in favor of a dispute resolution system used in the group health environment and in other state's workers' compensation systems is well worth a serious discussion. We certainly agree with the Commission that more research is necessary, especially in the area of disputed claims (whether AOE/COE or disputed issues on accepted claims), the role of the AME/QME process in resolving treatment disputes¹², and resolving issues regarding what appears to be a seriously anemic statute of limitations. As to the latter, however, it should also be noted that the business of lien filings and collections is at least in part a

¹⁰ The obligation to provide interpreter services is set forth in Labor Code § 4600(f) and applies only to "examinations".

¹¹ One issue not discussed is whether the cost of processing liens falls equally on all liens. In other words, the universe of liens currently on file with the WCAB may not equate to all liens being "active" and thus requiring payers to expend resources to dispute, settle, or pay. A duplicate lien that is not filed may have no cost savings associated with it.

¹² While not discussed, Independent Medical Review (IMR) remains a viable consideration to resolve treatment issues within the workers' compensation system.

symptom of an antiquated process and that perhaps it is the process that now requires change.

Thank you for your consideration of these comments.

Sincerely,

Mark E. Webb
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TO: CHSWC

The proposed recommendation issued by the CHSWC was drafted to deal with the number of liens being filed in the state's worker's compensation system.

This letter will establish solutions and recommendations and outline the irrevocable and irreversible consequences, if the recommendations outlined in the CHSWC report, pertaining to interpreters, is mandated.

Not only will these recommendations impact the interpreting profession, it will undeniably effect all non- English speaking injured workers, as well as all communities and counties as a whole in the following ways:

1. The injured worker will be denied their due process to have an interpreter for all proceedings prescribed in the labor code.
2. The outcome of a worker's compensation proceeding may be affected either postponed and or delayed due to a lack or shortage of certified interpreters which will develop as a consequence of the proposed recommendations.
3. Interpreters, interpreting agencies and their employees will be subjected to financial hardships that will cause a direct negative impact in the community.

Why punish the interpreting profession simply because the WCAB and the CHSWC cannot and will not look at the real reasons why there is an overload of lien filings in the worker's compensation system?

Tony Barriere Interpreting Service is trying to set goals in order to help educate the CHSWC to find a solution, so that lien filings can be

reduced without putting the welfare and livelihoods of hundreds and thousands of people in complete and utter disarray.

The following are recommendations for the solutions to the lien filing problems (pertaining to interpreters) for the CHSWC to consider:

1. Enforce the existing regulations in the LC and CCR's outlined in the following labor code sections:
4600 (f), 5811, 5813, 5814, 9793, Article 5.7, 9795.1, 9795.2, 9795.3, 9795.4,
2. Hold the insurance companies accountable for perpetuating a dysfunctional system.
3. Develop a REAL investigation into the reasons why the system is failing. It is the responsibility of the CHSWC that the injured worker, and the interpreters who serve them, and countless other entities be protected.

The interpreters are the communicators and voice of the non-English speaking injured worker and it is vital that the recommendations are considered in order to uphold the integrity of the worker's compensation system.

Thank you for this opportunity to comment

Tony Barriere Interpreting Service, Inc.

By: Tony Barriere

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Burbank, CA 91505



California Medical Association

Physicians dedicated to the health of Californians

January 3, 2010

Commission on Health and Safety and Workers Compensation (CHSWC)
1515 Clay Street
Oakland, CA 94612

Re: CMA Comments on Draft Lien Report

Members of the Commission:

On behalf of the California Medical Association (CMA), thank you for the opportunity to comment on Draft Liens Report prior to its publication. This report offers an important opportunity for CHSWC to look at the issue of liens in the workers' compensation system in a thoughtful and productive way.

CMA acknowledges that there are excesses in the use of liens which should be curbed. At the same time, liens are often the only tool that physicians have in order to seek fair reimbursement. The right of a physician to file a lien must be preserved.

With that in mind, CMA respectfully offers the following comments on the draft version of the Lien Report:

1. The Lien Report fails to adequately consider the effect of payor actions that necessitate the use of liens.

In constructing this report, the researchers relied heavily on the input of insurers and claims administrators. By their own admission, they did not survey or consult with physicians who provide care to injured workers.

Because of this, the report makes only the barest mention of negative payor activities which force physicians into filing liens in order to receive proper reimbursement or, in some cases, to receive any reimbursement at all. Examples of some of these activities include claiming unwarranted discounts, engaging in excessive treatment authorization or utilization review (UR) activities, downcoding of claims, and failing to abide by statutory timeframes for responding to requests for treatment.

For example, the report points out that physicians often file liens for care that was provided without proper authorization. In many of those cases physicians have requested authorization for these services and not received responses from the payor within the statutory timeframe. The physician has to rely on using a lien in order to provide timely care to an injured worker.

CMA recommends that CHSWC engage in further study with practicing physicians regarding the causes of filing liens. We would be happy to help you connect with physicians who treat injured workers who could provide you with their perspective.

CMA further recommends increased enforcement and sanctions for payors who do not pay physicians promptly and in full according to existing statutes and regulations.

2. If a filing fee is reinstated, it should be carefully constructed so it does not create an incentive for payors to underpay physicians.

CMA agrees that a filing fee could be a powerful deterrent against frivolous lien filing. It could also, however, have the effect of creating an incentive for payors to consistently underpay physicians.

If the filing fee were set at \$100, payors could consistently underpay physicians on every claim by amounts up to \$100. The physician would have no incentive to seek proper payment if the filing fee were above the amount of the underpayment. While this would only have a minor effect on any one claim, for physicians who treat many injured workers, the cumulative effect could be substantial. Ultimately, this could affect the willingness of physicians to accept workers' compensation patients, and harm access to care.

CMA would recommend that, if the filing fee were to be reinstated, that there be a "loser pays" provision, whereby the payor would be required to reimburse the physician for the filing fee if the court finds that the payor underpaid the physician.

3. CMA supports the recommendation for an administrative review process for resolving minor fee disputes.

Physicians do not want to have to file a lien. They are a slow, expensive, and inefficient means of receiving payment. Most physicians view filing a lien as a last resort, albeit a necessary one.

In order to reduce the need for liens, CMA has consistently supported policies similar to Recommendation #6, which would create an objective administrative process for resolving minor fee disputes without having to resort to the use of a lien.

Many fee disputes could be resolved by simply comparing the treatment provided to the Official Medical Fee Schedule (OMFS) or to a contracted rate. CMA believes that DWC, if given proper staffing, could handle many of these disputes and move them out of the court system. This would be a more efficient process for everyone involved.

This, again, could be funded through a "loser pays" system, where the filing fee would be paid by whoever is ultimately found to be wrong in the fee dispute.

4. CHSWC should consider researching the use of targeted interventions to reduce the use of liens in specific geographic areas or by certain groups of providers.

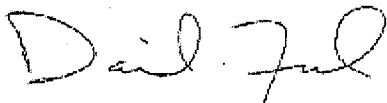
While the lien problem is, in aggregate, an enormous drag on the workers' compensation system, the report points out that the vast majority of liens are clustered into certain geographic regions, providers, and services. Rather than target all providers based on the actions of a few bad actors, CHSWC should consider whether there could be some targeted interventions in those areas where excessive use of liens is found to be prevalent.

5. If a Statute of Limitations is imposed, it should be based on the date that a physician becomes aware that an injury is work-related, not the date of service.

Recommendations 13 through 16 all relate to the concept of limiting the amount of time a physician has to file a lien after the date of service. The problem with these recommendations is that physicians may not be aware on the date of service that an injury is work-related. In some cases it may be six months or more before the physician has that information. Therefore, any statute of limitations that is imposed should be based on that date that a physician becomes aware that an injury is work-related, and not the date of the original service.

Thank you in advance for your consideration of our comments. CMA looks forward to working with CHSWC on this and many other issues related to the treatment of injured workers.

Warm Regards,

A handwritten signature in dark ink, appearing to read "David Ford", with a stylized, cursive script.

David Ford

Associate Director, Medical and Regulatory Policy.

Re: Lien Report/ Interpreting Services

Veronica with Nunez & Barrera Interpreters [Nunezinterp_Veronica@adelphia.net]

Sent: Monday, January 03, 2011 2:21 PM**To:** CHSWC@DIR

CHSWC,

We have reviewed the CHSWC Liens Report Draft dated 12/16/10. We have addressed our concerns and comments regarding Recommendation 25 and anticipate that it will be taken into consideration.

Pursuant to the Judicial Council, it has been reported that they currently have 1,149 active statewide Superior Court interpreters. The State Personal Board has reported that there are currently 352 statewide administrative hearing interpreters and 285 statewide medical interpreters. Based on the above-referenced number of active administrative hearing and Superior Court interpreters, it is evident that there is an insufficient supply of available interpreters to meet the daily demand. Therefore, limiting an interpreter to how many cases they're able to perform in a given day will cause a drastic delay on the cases that need to be heard at the Workers' Compensation Appeals Board (WCAB); consequently, violating the injured workers right to due process.

Defense attorneys and hearing representatives are not restricted to the number of hearings that they are allowed to service in a given session. In most cases, they bill their clients individually per hearing, regardless if the attorney or representative is independent or employed by a law firm. Defense law firms, interpreters and interpreter agencies are all private, free-enterprises and should be allowed to conduct their businesses in the same manner.

The only issue of common law and fact is the non-payment from insurance carriers. Interpreters are not the reason for the backlog of Liens that are being filed with the WCAB; however, it's due to the lack of cooperation from Defense counsel and insurance carriers refusing to pay and/ or negotiate our liens. Moreover, insurance carriers are denying cost liens and services as allowed per Labor Code (LC) § 5811 & California Code of Regulations (CCR) § 9795.3 by sending non-substantiatable and non-applicable boilerplate objection letters to further delay payments; thereby, attempting to circumvent applicable penalties & interest pursuant to CCR § 9795.4. This constitutes a probable, usual & customary bad-faith action on behalf of insurance administrators. Accordingly, in compliance with the insurance adjusters' remedy directives listed on their objection letters and CCR § 9795.4 (a), we are mandated to adjudicate our issues before the WCAB judges; thereby, requiring us to filing a lien.

It is stated in your report that 'the survey did not request information about the causes of interpreter liens'. This is a MAJOR short coming with the report! At this time, we request the committee to investigate the "true cause" of Interpreter lien filings.

Sincerely,

Veronica S. Perez
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January 3, 2011

TO: Commission on Health and Safety and Workers' Compensation (CHSWC)

FROM: Philip Boehm, Boehm & Associates

RE: Comments on the Draft Liens Report

Judge Taylor provided a comprehensive and conscientious study of lien problems in workers' compensation. We believe nonetheless that some of the recommendations deserve further consideration.

REPORT RECOMMENDATION 10

Recommendation 10 limits the duration of covered treatment, unless the worker files a Declaration of Readiness (DOR) within a yet to be designated period of time.

Issue:

It would appear that the recommendation is directed at medical care provided in cases where the employer/carrier accepts liability for an injury or condition and provides Labor Code Section 4600 benefits, but disputes responsibility for some aspect of the medical treatment on reasonably believed legal grounds. If this is the case, any proposed legislation should so specify.

Our concern stems from our experience representing many public and private hospitals, the Department of Veterans' Affairs, Medi-Cal and health plan payors. Many of our clients are required by law or contract to provide or pay for care when a workers' compensation carrier refuses to accept liability, or to provide medical treatment benefits. In other cases, indigent patients receive hospital care at county facilities at public expense or at private hospitals on a charitable basis. At the time of admission, there may be no knowledge of a workers' compensation case, or this may be the worker's only alternative access to necessary medical treatment. In these situations, the worker may lack the knowledge or motivation to pursue his or her case within the proposed statutory deadlines applicable only to the lien claimants. In these instances, the worker receives treatment because the employer/carrier has denied liability for care or failed to provide necessary treatment. The worker has no imminent reason to activate the case before the Board, yet the lien claimant's clock continues to tick while its hands are tied by Labor Code 4903.5(c) proscriptions that forbid it from filing a DOR to

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protect its own interest. In other words, liens could be dismissed as untimely by operation of law and without any opportunity for the lien claimant to access the court.

Recommendation 10 also leaves unanswered the question of who will pay for this medical treatment. Would the applicant who failed to file a Declaration of Readiness on the issue, but nonetheless received the benefit of medical care be held responsible to pay for medically reasonable and appropriate treatment? Would the Board retain jurisdiction to order the applicant to pay for his own medical treatment?

REPORT RECOMMENDATIONS 11 & 12

Current Board Rule 10770.5, provides reasonable parameters for the timing of lien filing. If a lien is truly "premature" and the claims administrator conducts itself appropriately, one of two things will occur:

- (1) The bill will be paid properly and the lien will be withdrawn, or
- (2) The claims administrator will underpay or reject the bill and the lien should have been filed anyway.

The proposed amendment of Labor Code Section 4903.6 and 10770.5 may delay the filing of a minority of liens, but will have a negligible net effect on ultimate filings. The amendments may, in fact, encumber the Board further because defendants will routinely raise premature filing as an affirmative defense and lien claimants will request more hearings to determine whether there is an actual violation of the proposed statute.

REPORT RECOMMENDATION 13

Recommendation 13 suggests that the statute of limitations should bar a lien for medical treatment unless the provider has billed the claims administrator within 60 days from the date medical treatment services were provided.

Issue:

In many cases, the liable employer is not even readily identifiable at the time of medical services are provided. If medical providers are denied payment on the technical ground that they could not identify and bill the employer within 60 days from treatment, the many workers who were not directed to an MPN by their employer would lose access to medical care. The following is a small sample of the many instances in which the identity of the proper employer/carrier is not readily available:

- General/special employer situations;
- Allegations of independent contractor or subcontractor liability;
- Multiple dates of injury for the same body part with different employers;
- The patient himself or herself is unable to provide accurate information regarding the appropriate employer contact for reporting a claim (e.g. where an injury renders a patient unconscious);
- An employer is uncooperative in providing claims and coverage information to the provider;

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- Coverage remains undetermined for years and the UEBTF is eventually joined;
- The parties (applicant and defendant) fail to disclose to medical providers or lien claimants the identity of the correct claims administrator, or even the correct claims office location;
- The claims administrator changes and lien claimant fails to serve the correct administrator within the requisite 60 days.

Additionally, a 60-day statute of limitations on lien claimants could produce many paradoxical results because an injured worker has a longer statute of limitations to file his or her application: up to one year or longer if exceptions apply. For example, an employee may receive diagnostic treatment for a condition that is not diagnosed as work-related until more than 60 days have elapsed since the lien claimant's treatment was provided. This is a common scenario in heart and cancer (including asbestos) cases where latency periods are in dispute.

The recommendation also conflicts with Labor Code Section 5412, which sets forth the definition of the date of injury for cumulative trauma cases: "the date upon which the employee first suffered disability there from and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment." If Recommendation 13 were implemented, it is foreseeable that an injured worker's claim for benefits would be timely despite being filed over 18 months after the onset of a cumulative trauma injury. The treatment liens for hospital bills would not be the liability of the employer/workers' compensation carrier because of the delayed discovery of the industrial nexus. The injured worker would therefore be denied the workers' compensation medical treatment benefit and instead might be faced with liability for his or her medical bills. This conflicts with the basic intent of the workers' compensation system that provide for all necessary medical treatment to cure and relieve the effects of industrial injuries.

Health care insurers would be unable to present bills to employer/carriers within 60 days of treatment. It is hoped that in the event the proposal is adopted, the health insurer exception discussed on page 38 of the Report will apply to Recommendation 13 as well.

REPORT RECOMMENDATION 16

Recommendation 16 imposes an automatic dismissal of liens not activated within one year from the time the case-in-chief resolves.

Issue:

Very often lien claimants are not served with settlement documents and have no knowledge that the underlying case has been resolved.

Current board Rule 10886 requires service of the compromise and release or stipulated award on the lien claimants of record. Nevertheless, many defendants neglect this requirement. Defendants should face sanctions if they fail to comply with the service requirements. Additionally, any statute of limitations that requires a lien claimant to activate a case within a specified period of time after the case-in-chief has settled should be tolled if the lien claimant is not served with settlement documents.

EXTENSION OF THE HEALTH INSURER EXCLUSION TO INCLUDE PUBLICALLY FUNDED HEALTH CARE PAYORS AND PROVIDERS WHO ARE LEGALLY REQUIRED TO PROVIDE MEDICAL TREATMENT

We applaud the Report's recognition of health insurers as a distinct breed of lien claimants. We would ask that the same recognition be extended to publically funded medical providers and payors who are similarly required to provide benefits when and workers' compensation claim is in dispute. These entities include the Department of Health Care Services (Medi-Cal), Medicare, the Department of Veterans Affairs, county hospitals, and public and private hospitals who are legally obligated to provide medical care to indigent patients.

SUGGESTED REMEDIES TO ADDRESS THE LIEN BACKLOG:

The backlog of liens is in no small part a result of the deferral of lien issues until the case in chief has been resolved. While we do not suggest that lien claimants be empowered to file DOR's prior to the resolution of the applicant's case, we do recommend that WCJ's actively encourage both lien claimants and defendants to take meaningful steps to resolve lien claims in accepted cases prior to the resolution of the case-in-chief. This would greatly reduce the accumulation of liens.

The following recommendations are made with a view to reduce the backlog and streamline the resolution of lien issues:

1. ENFORCE THE PROVISIONS OF BOARD RULE 10886 & 10888 AND EMPLOY SANCTIONS FOR THE FAILURE OF THE DEFENDANT TO COMPLY.

Current Board Rule requires defendant to make a "good faith attempt to contact the lien claimants and resolve their liens. A good faith attempt requires at least one contact of each lien claimant by telephone or letter." This rule is more often ignored than fulfilled. Our office is only occasionally contacted by adjusters or attorneys prior to the resolution of the applicant's case. When we are contacted, more often than not it is with (1) a telephone call from a secretary who verifies lien balances and has absolutely no authority to resolve a lien or (2) a letter advising the case is settling, and asking for the lien balance and a demand – with no authority on the part of defense counsel to resolve the lien. Requiring both defendants and lien claimants to have bona fide authority at the time of these "good faith efforts" would go a long way toward transforming these mere exchanges of information into successful negotiations.

2. ENFORCE THE PROVISIONS OF BOARD RULE 10109 IN CONNECTION WITH THE MANDATORY APPEARANCE PROVISIONS OF BOARD RULE 10240 AND EMPLOY SANCTIONS FOR THE FAILURE OF THE DEFENDANT TO COMPLY.

Board Rule 10109 mandates defendant's duty to conduct a reasonable and timely investigation in good faith regarding "each benefit" which may be due the applicant. It further provides that the duty of good faith extends to "all claimants, including lien claimants."

Medical treatment lien claimants are regularly told by adjusters and their attorneys that they will not deal with any lien resolution issues until the case-in-chief resolves. It is not uncommon for defendants to ignore medical bills for accepted injury claims--even authorized treatment bills-- for years until the case-in-chief finally resolves by way of C&R or Stipulated Award.

It is also not uncommon for defendants to state at lien conferences that their clients require more time to review the bills (which they have had in their possession for years), and to request continuances, which are granted. If continuances are not granted, then the case is again ordered off calendar for discovery.

Board Rule 10240, which became operative in November 2008, requires all lien claimants with lien claims of \$25,000 or more in accepted claims to appear at the Mandatory Settlement Conference. In Southern California in particular, defendants are rarely, if ever, prepared to discuss lien resolution, asserting they will not negotiate until the case in chief resolves. Most judges are reluctant to press defendants regarding their lack of preparedness or lack of willingness to resolve & to eliminate these lien issues prior to conclusion of the case in chief. At most, in lieu of an actual order requiring defendant to review the treatment bills in an accepted claim, judges will merely note that the defendant agrees to review the bills.

Requiring defendants to arrive at the MSC prepared to resolve treatment liens in accepted claims would significantly reduce the backlog of liens as the applicants' cases make their way through the system. If enforced, a minor amount of liens would remain by the time the case-in-chief would actually resolve.

Enforcing the requirements of 10109 and 10240 with the imposition of sanctions would provide the necessary motivation for defendants and lien claimants to resolve lien issues in accepted claims promptly.

Respectfully submitted,

Philip Boehm

CHSWC Liens Report – December, 2010

Doug.Benner@kp.org [Doug.Benner@kp.org]

Sent: Monday, January 03, 2011 1:18 AM**To:** CHSWC@DIR**Cc:** Baker, Christine@DIR; Taylor, Lachlan@DIR; linda.loza@kp.org; Connie.Chiulli@kp.org

To: Commission on Health and Safety and Workers' Compensation
Emailed to: chswc@dir.ca.gov**From:** Kaiser Permanente
Doug Benner, MD
Regional Coordinator, Occupational Health
510-625-2424
doug.benner@kp.org**Date:** December 30, 2010**Re.:** CHSWC Liens Report – December, 2010

On our review of your December 2010 draft of the Liens Report, we were surprised with the report's findings and statistics regarding lien claimants. Here in Northern California we've had little or no experience with the lien issues presented in your report nor with the huge problems they cause.

Southern California lien claimants' practices are alien to Kaiser Permanente; for instance, we use EAMS to file liens electronically, we only file liens when we have confirmation of a denial from a Claims Administrator, we file amended liens electronically, we list our legal representatives, attorneys, on our lien, and we do not file premature nor zombie liens. The differences between Northern and Southern California are startling.

In regards to the Liens Report, we have some concerns and comments which we have detailed below.

If you need clarification or have questions, please contact me.

Recommendation #1 – Reinstate a filing fee for medical and medical legal liens.

must have assurance on the availability of a technology, including EAMS, to support the DWC's tracking of lien filing fees and the confirmation that a lien filing fee has been paid

all lien claimants must be subject to a lien filing fee to prevent denial of due process and equal protection to medical providers

defense must be prevented from using the lien filing fee as tactic to stop continuing medical payments on a disputed case where medical treatment is not at issue

Recommendation #6 – Establish an administrative system for fee schedule determinations, subject to limited judicial review.

all parties must be at the table to achieve maximum administrative success
neutral arbitrators must be recruited to review billing specifics
funding must be secured for new administrative system

Recommendation #10 – Consider establishing a maximum duration for treatment that can be claimed by lien in the absence of a Declaration of Readiness by the worker to seek authorization for the workers' chosen provider.

establishing maximum duration for treatment prevents recovery of rendered medical treatment and services for health care providers who continue to treat the injured worker per health plan coverage resulting in no incentive for the injured worker to file a Declaration of Readiness to seek authorization for continued care.

establishing maximum duration for treatment prevents recovery of rendered medical treatment and services for medical care providers who initially treat a worker on a non-occupational basis and later learn of a workers' compensation claim

establishing maximum duration of treatment prevents recovery of rendered medical treatment and services for medical care providers who assume the treatment of a worker after the worker has changed their medical insurance plan

Recommendation #13 – Enact a statute of limitations, effective prospectively based on date of services to bar any lien unless the service is billed in accordance with regulations and the lien is filed within a defined time following that service.

And

Recommendation #14 – Enact a statute of limitations to bar any lien for service, regardless of date of service, that is not filed within three years of the date of medical services.

this statute will result in medical providers filing liens and/or filing WCAB applications in order to protect their lien rights

this statute prevents recovery of rendered medical treatment and services for a health care service plan's medical providers who initially treat a worker on a non-occupational basis and later learn of a workers' compensation claim

this statute prevents recovery of rendered medical treatment and services for a health care service plan's medical providers who assume treatment of a worker after the worker has changed their medical insurance plan

this statute prevents recovery of rendered medical treatment and services for a health care service plan's medical providers who have treated workers and later learn of newly filed WCAB cumulative trauma applications

section 4903.5 should be retained as SOL to avoid any of the above problems

Doug Benner

Douglas Benner, MD

Coordinator – Occupational Health

Medical Director – Employee Health Services and MPN Networks

The Permanente Medical Group, Inc. – Northern California

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Vela, Oliva@DIR

From: Doug.Benner@kp.org
Sent: Monday, January 03, 2011 2:06 PM
To: Taylor, Lachlan@DIR
Cc: Baker, Christine@DIR; CHSWC@DIR; Connie.Chiulli@nsmtp.kp.org; Linda.Loza@nsmtp.kp.org
Subject: RE: CHSWC Liens Report – December, 2010

Lach,

Thanks for the quick response, I will respond to the questions you raised:

Filing fees for liens:

-Overall I have grave concerns of proposing something that will likely fail in implementation or will be a further administrative burden on the DWC/WCAB as well a lien claimants. We have heard of great difficulties the state had in attempting this before and how payors used the process as another way to refuse payments unfairly.

-Your report states the purpose of the filing fee is for "merely to cope with the volume of liens and the burden they place on the dispute resolution process". If so, then the "relief" should be applied across the board based on volume, thus for ALL LIEN Claimants, otherwise it is discriminatory.

Statue of Limitations

I have and will remain opposed to SOL's for providers based on date of service. Patients frequently do not even know themselves they have industrial claim rights for the condition they seek care for OR have serious and rightful fear of retaliation including loss of employment for filing an industrial claim and therefore do not tell the employer of the industrial causation. Some or even directly instructed by their employer to NOT file an industrial claim. For ALL providers, then the SOL should begin to run from DATE OF KNOWLEDGE of the provider.

-We were personally pleased to see the unique burdens of health care service plans addressed in #17 but would be opposed to your option linked to date of service.

Doug Benner

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"Taylor, Lachlan@DIR" <LTaylor@dir.ca.gov>

01/03/2011 01:25 PM

To Doug Benner/CA/KAIPERM@KAIPERM, "CHSWC@DIR" <CHSWC@dir.ca.gov>

cc "Baker, Christine@DIR" <CBaker@dir.ca.gov>, Linda
Loza/CA/KAIPERM@KAIPERM, Connie Chiulli/CA/KAIPERM@KAIPERM

Subject RE: CHSWC Liens Report – December, 2010

Doug, I think we are generally in agreement. Most of your concerns are consistent with the draft recommendations, and they are matters to be considered when these general recommendations are taken up for implementation by statute or regulation.

Vela, Oliva@DIR

Subject: FW: CHSWC Liens Report – December, 2010

From: Doug.Benner@kp.org [Doug.Benner@kp.org]

Sent: Monday, January 03, 2011 4:39 PM

To: Taylor, Lachlan@DIR

Cc: Baker, Christine@DIR; CHSWC@DIR; Connie.Chiulli@nsmtp.kp.org; Linda.Loza@nsmtp.kp.org

Subject: Re: CHSWC Liens Report – December, 2010

Lach

You may include the emails in the record.

Doug

"The difference between a successful person and others is not a lack of strength, not a lack of knowledge, but rather a lack in will."

– Vince Lombardi

Sent by Blackberry from:

Douglas Benner MD

Coordinator Occupational Health and Medical Director - Employee Health Services and MPN Networks.

Kaiser Permanente NCAL. Office: 510-625-3133. Assistant: Annie Pang 510-625-2355. Fax: 510-625-3037

Interpreter Comments RE: CHSWC DRAFT Lien Report

Guadalupe Manriquez [lmis_inc@yahoo.com]

Sent: Monday, January 03, 2011 4:46 PM**To:** CHSWC@DIR

Dear CHSWC,

In review of The California Commission on Health and Safety and Workers' Compensation's *DRAFT* Liens Report for *Public Comment* dated 12/16/10, we have the following concerns in regards to your Recommendation #24 for the Administrator Director.

"Recommendation 24: Either regulation or statute should be adopted to clearly prescribe the events for which interpreter services are payable."

Pursuant to California Government Code (CGC) §11435.05, it defines "language assistance" as oral interpretation or written translation into English of a language other than English or of English into another language for a party or witness who cannot speak or understand English or who can do so only with difficulty.

Therefore, interpreters rendering language assistance in the Workers' Compensation system are providing their services to non-English speaking injured workers as a conduit for equal communication in compliance with CGC §11435.20. This code explicitly mandates the hearing, or any medical examination conducted for the purpose of determining compensation or monetary award, shall be conducted in English. For this purpose, we find California Code of Regulation (CCR) §9795.2, Notice of Right to Interpreter, as the injured workers' fundamental right to language assistance for all Workers' Compensation events –legal & medical.

The insurance carrier administrators and defense attorneys have offensively & repeatedly circumvented liability for fees for interpreter services as already prescribed in CCR §9795.3 (a) & (b) since 12/30/96, including, but not limited to its subsection (a) 1-7 that allows the Workers' Compensation Appeals Board (WCAB) to determine reasonableness and necessity to determine the validity and extent of injury to an employee. The compensability of these events are subjected to the 15-year existent California Government and Workers' Compensation statutes due to the purpose of proving or disproving a work-related injury, which are industry-specific rather than those general events prescribed under Federal Executive Order 13166.

Moreover, as stated in the AMA's Guides, Fifth Edition, Section 1.8 - Impairment Evaluations in Workers' Compensation, "In the United States, workers' compensation is a no-fault system for providing cash benefits, medical care, and rehabilitation services to individuals with work-related injuries and diseases...The claimant receives payments to compensate for lost wages due to temporary total, temporary partial, permanent total, and permanent partial disability...Medical information is essential for the decision process in these cases...Impairment assessment is a necessary *first step* for

determining disability.”

In cases, where the injured worker is non-English proficient, the controversial question is ‘how would a physician, commissioner or hearing official be able to properly determine the injured workers’ impairment assessment without the use of an interpreter considering the hearing and any medical exam must be conducted in English?’ This concept is understood to mean inclusion of medical evaluations that contribute to the impairment assessment process.

We are not alone in the above-stated concept as demonstrated by legislative intent, general insurance industry common practice, WCAB rulings, and common sense. Some of the WCAB rulings on point including, but not limited to, are the following:

- WCAB Case LBO 0357008 – Gerardo Perez. “The only issue at the July 12, 2007 trial was the reasonableness and necessity of lien claimant’s lien for interpreting services provided at treating physician appointments occurring at 45-day intervals as required by Administrative Director Rule 9785(f)(8).”

Panel Judges Moresi, Miller, & O’Brien granted reconsideration, rescinded WCJ’s decision, and issued a new Findings and Award on October 16, 2007, “reversing the WCJ to allow lien claimant’s (interpreter) lien in full for services provided at follow-up visits with applicant’s treating physician at 45-day intervals as required by AD Rule 9785(f)(8).” Lien claimant (interpreter) contended that the “WCJ erred in not allowing its lien in full arguing that interpreter services are allowable under Labor Code section 4600.”

Panel judges based their final decision on two key analyses. First, the relevancy of said services in connection with medical services listed in Labor Code Section 4600 “that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer” (As analogized from *Hutchinson v. Workers’ Comp. Appeals Bd.* (1989) 209 Cal.App.3d 372 [54 Cal.Comp.Cases 124] regarding the cost of transportation to medical appointments). Second, they concurred with the panel decision of *Garcia v. State Compensation Insurance Fund* (2001) 29 CWCR 310, wherein WCJ noted that “[E]ffective communication between doctor and patient is an essential component of medical treatment and the healing process. An accurate history and clear understanding of the patient’s subjective complaints are imperative if the treatment is to cure and relieve from the effects of the injury.”

- WCAB Case STK 172076 – Carlos Chavez. “The sole issue for the court’s determination at this time is: 1. Is the applicant entitled to Spanish interpretive services at his medical treatment appointments?”

Judge McEvilly ordered a mutually agreed stipulation that “...defendant will provide Spanish language interpretive services for applicant at applicant’s treatment appointments with Dr. Jakubowski”, the primary treating physician.

- WCAB Case BAK 139325 – Pia Hidalgo. Defendant claimed, in its trial brief that “whatever

obligation an insurance carrier or an employer has to administer benefits is defined strictly by statute..." "Nowhere in the Labor Code does it provide that interpreting services for the purpose of treating an injured worker are reimbursable", and Until the legislature acts and specifically mandates such reimbursement, the courts cannot do so."

Lien claimant asserted (sic) this is not so "... and the Board is not devoid of power. In fact, WCAB's authority to award interpretation fees and other cost is plenary. The board has authority over proceeding "for the recovery of compensation, or any right or liability arising out of or incidental thereto." Op. cit. L.C. §5300(a). Other assertions were offered.

Judge Kathleen M. Ortega "... found that lien claimant (interpreter) is entitled to payment of their lien, for all unpaid dates of service in the amount of \$2,120.00 and the interest at the prevailing rate." Judge Ortega also referenced CCR § 9795.3(a) as specific authority.

Accordingly, we request that the commission thoroughly conduct a balanced investigation into the real causes of interpreter lien filings before *ANY* recommendation can be formed or presented to the Administrative Director and the DWC staff for an anticipated balanced government policy. Hence, all recommendations should be moot until further discovery is obtained, evaluated, and a decision is reached.

Sincerely,

LMIS, INC.

By Andrea Manriquez

C/o Lupe Manriquez, State Certified Medical Interpreter

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TheZenith

January 3, 2011

State of California
Commission on Health & Safety and Workers' Compensation
1515 Clay Street, Room 901
Oakland, CA 94612

Re: CHSWC Draft Liens Report for Public Comment

Gentlepersons:

Zenith Insurance Company hereby submits its commentary on the Commission on Health and Safety and Workers' Compensation's Draft Liens Report for Public Comment together with additional proposed recommendations for the Commission's consideration.

Workers' compensation is supposed to be an administrative system in which recourse to a WCJ should only be had in the event of a good faith dispute. Nonetheless, great numbers of lien disputes involve anything but good faith. While there are defendants that pay less than what they owe for a variety of reasons, the more significant problem is lien claimants who engage in nuisance value litigation in order to obtain more than what they're entitled to be paid. This type of abuse cannot be cured by statute and regulation and increased staffing because it has nothing to do with either the merits of the claim or the DWC's ability to enforce the law. Rather, such abuse can only be controlled by modifying the procedures of the DWC in litigating lien disputes.

Many, if not most lien claimants bill in excess of the applicable fee schedule or reasonable value. Even if the defendant has paid the proper amount, the lien claimant may bring the matter down to the DWC office to collect the "balance," assigning the appearance to a lay representative who is being paid a nominal appearance fee plus a percentage of whatever can be collected and who may have as many as 25 lien cases set on the same date. The defendant sends a private attorney who is billing at an hourly rate, including preparation time and travel, and who has to remain at the Board until the lien representative has the time to deal with him. Facing the potential of multiple appearances, it is more cost effective for the defendant to pay than to fight. The success with which these tactics are met only encourages more of the same. Removing these disputes from the DWC offices, as set forth in Recommendation No. 6, would go far to relieve the pressure at the DWC and prevent abuse on both sides.

Since the regulations require service of medical reports on lien claimants, a great deal of time at the DWC offices is taken up by disputes over whether documents have been served or received. If the defendant is disputing liability for the lien on the basis of the medical evidence, lien claimants are certainly entitled to examine that medical evidence. However, in the cases that are limited to fee schedule disputes or disputes concerning whether the injured worker was properly

in a Medical Provider Network, the content of the medical reports bears no relevance whatsoever to the merits of the dispute. Therefore, the regulation should be amended to provide that if the defendant stipulates in writing that it is only disputing reasonable value or network control, no service of medical reports should be required.

The recommendations that are designed to force providers to file liens within certain time limits would be beneficial in that they would bring lien disputes before the DWC in a more timely fashion and would stop the practice of delayed lien filing in order to deprive the DWC of jurisdiction over the dispute. However, the likely outcome is that the providers would simply file their liens timely and there would be little impact on the manner in which lien litigation is conducted. In fact, timely filing of liens would initially increase the litigation and the pressure on the DWC offices.

Enactment of new statutes and regulations and fee schedules would ultimately be of great benefit, but would involve a lengthy process and would then only apply prospectively. After the schedule for outpatient surgery center facility fees was adopted in 2004, the litigation over the pre-2004 dates of service continued unchecked until 2009 when the WCAB issued the *Tapia* en banc decision making it easier to determine reasonable value in the absence of a fee schedule. Additional en banc decisions concerning the determination of reasonable value for other types of medical services would help to fill the gap between the present cases and the ones that will be subject to new fee schedules.

Zenith believes that the greatest chance of success lies in modifying the Board's procedures in adjudicating lien disputes with the goal of limiting access to the DWC offices and eliminating the nuisance value litigation. The first step would be to remove pure fee schedule disputes from the DWC District Offices and to institute an administrative process, limited to a paper review, with no right to an in person hearing. This is discussed further under Recommendation 6 below. Furthermore, it would be beneficial to eliminate the requirement for defense service of medical reports on lien claimants if the defendant stipulates in writing that the only disputed issue is the proper application of the fee schedule and/or whether or not the defendant obtained network control.

Another suggestion is that lien claimants be required to file a Substitution of Attorneys/Representatives every time they decide to retain a new independent representative who isn't the lien claimant's employee. Presently, each appearance before the DWC often comes with a new representative who may claim unfamiliarity with the dispute or lack of documentation.

If the WCAB issued en banc decisions concerning unsettled issues that come up on a regular basis in lien disputes, this would be very beneficial since the decisions could be issued relatively quickly, would for the most part have retroactive effect, and would be binding unless and until overturned by the Court of Appeal.

The procedures that Presiding Judge Jorja Frank has instituted at the Los Angeles District Office should become a model for the rest of the state. Without any change in statute or regulation, she has implemented procedures that have streamlined the adjudication of lien disputes and have made it much more difficult for the parties to profit from bad faith tactics and nuisance value litigation.

It would be very helpful if judges could receive training in uniform procedures for handling lien disputes, preferably involving Judge Frank. Presently, there are almost no official lien procedures and most WCJs are justifiably confused about the best way or even the proper way to approach the problem.

The DWC needs to adopt an official form pre-trial conference statement for lien trials that addresses the actual issues that are in dispute. The 5-pager used in the case in chief is practically worthless for this purpose. However, it is used because there is nothing else.

Even if all of the Commission's recommendations were implemented, the sheer magnitude of the problem would still make a complete resolution of the problem impossible. Therefore, the DWC should implement procedures to encourage bulk settlements between a single lien claimant and a single or multiple defendants. One way of accomplishing this might be to select judges who have the requisite knowledge and interest, and train them in effective mediation techniques that could be uniformly applied to any lien dispute.

There is one procedure that would eliminate almost all of the lien litigation at the DWC District Offices if it were implemented. This would be to require that no Compromise and Release be approved until the liens have been resolved. The Policy and Procedural Manual imposes this requirement for settlements between the applicant and an uninsured employer. Prior to the revision of the Compromise and Release form in the early 1980s, liens were invariably resolved in connection with a settlement.

The following is Zenith's commentary on each of the individual recommendations together with additional proposed recommendations.

Recommendation 1: Reinstate a filing fee for medical and medical-legal liens

When there was previously a filing fee, it was ineffective because the DWC lacked the resources to collect and keep track of the fees and many providers simply stopped filing liens. In order to have an effective filing fee, the DWC must be given the authority to hire an outside collection service for this purpose with the funding to come out of the fees. Furthermore, unless there is a hard and fast statute of limitations for the filing of a lien, providers will choose not file liens to avoid payment of the filing fee. When this happens, the dispute cannot be resolved at the DWC offices because without a lien having been filed, there is no jurisdiction.

Recommendation 2: Require frequent lien filers to file their liens electronically

While it is true that this would cut down on clerical time, there needs to be some consequences for the electronic filing of inappropriate documents by lien claimants. Some lien claimants not only file their liens electronically, but also file every demand letter or other piece of correspondence that is sent to the defendant as well as every bill for every office visit.

Recommendation 3: Prohibit filing of amended liens prior to Declaration of Readiness

This is an excellent recommendation. However, again, if there are no consequences for the prohibited conduct and it's easier for the lien claimants' untrained office staff to file any and all documents, the prohibition will not be observed.

Recommendation 4: Until the volume of liens is substantially reduced by other measures such as recommended in this report, equip the WCAB District Office with sufficient resources to meet workloads.

This is an excellent recommendation. However, the real question is how to provide those sufficient resources with the current budgetary restraints. One way to make the resources of the WCAB better able to accommodate the flood of lien litigation is to consolidate commonly encountered issues on a statewide basis before a single WCJ.

Recommendation 5: Adopt medical fee schedules to cover those services that are often disputed due to gaps or ambiguities in the existing fee schedules.

This is an excellent recommendation. However, it would be a long term solution because it would have no effect on services performed prior to the effective dates of the new fee schedules.

Recommendation 6: Establish an administrative system for fee schedule determinations, subject to limited judicial review.

Fee schedule disputes should not come before a WCJ because they present accounting problems and not legal problems. If an insurance company has paid less than fee schedule, the medical provider should not have to wait several years until the case in chief resolves in order to be paid in full. Likewise, a defendant that has paid pursuant to the fee schedule should not have to engage in protracted and costly litigation over a bill that was properly paid.

One potential problem with this recommendation is the provision for "limited judicial review" where the aggrieved party would have an opportunity to show that the AD's determination is not supported by substantial evidence. Defendants would generally accept the DWC review as final because it would not be cost-effective to contest it. There would also be some providers that would accept the recommended payment. However, many providers, and particularly the abusive "balance billers" would simply demand a hearing before a WCJ in each and every case and then threaten to run up the defendants' legal costs unless additional sums are paid, over and above the review. In these cases, the right to adjudication at the DWC District Offices would nullify any benefit to be gained from the process.

The option of an in person hearing before a WCJ may not be necessary to satisfy due process considerations. For MPN disputes concerning diagnosis or treatment, Labor Code §4616.4 requires the Administrative Director to contract with individual physicians or an independent medical review organization to perform independent medical reviews for an appeal by way of the independent medical review process in for the MPNs. Perhaps a similar process would be suitable for appeals of bill reviews conducted by the DWC with a filing fee to defray the costs that would be reimbursed by the defendant should the lien claimant prevail.

Recommendation 7: The boundaries of MPN control over medical treatment should be more clearly defined to minimize the potential for disputes over rights to select medical providers.

While this is a good idea, it is not clear how this could be accomplished. There are currently two WCAB en banc decisions on network control. Generally, en banc decisions address general legal principles that aren't dependant on the facts of the individual case. There have been a number of WCAB panel decisions addressing various aspects of network control but none of them

constitutes binding precedent. It may be difficult to adopt regulations that would resolve all of the different factual scenarios that arise in MPN disputes.

Recommendation 8: Disputes over assertions of MPN control over medical treatment should be brought to adjudication promptly.

This is the only real solution to the problem. As soon as a bona fide dispute arises concerning treatment with a non-MPN provider, the dispute should promptly be taken to the DWC office for either an expedited hearing or an MSC and trial. The WCJ should make all necessary findings of fact to establish whether the injured worker was or was not properly in the MPN. Once these findings have become final, the non-MPN doctors will either be entitled to payment or will be put on notice that the defendant is not liable for treatment. This would eliminate the future lien litigation. Prompt determination of these issues will cause the disputes to dwindle as the outcome of any given case will become more and more apparent from prior decisions.

Recommendation 9: Sanctions should be imposed on providers and claims administrators alike to repeated patterns of incorrectly asserting or denying status of an authorized medical provider.

Sanctions would be an effective deterrent to disputes where one of the parties was not acting in good faith.

Recommendation 10: Consider establishing a maximum duration for treatment that can be claimed by lien in the absence of a Declaration of Readiness by the worker to seek authorization for the workers' chosen provider.

This is a good idea, but might present some due process problems since the one who stands to lose is the medical provider, not the injured worker who has already gotten the treatment. Until the case in chief is resolved, the lien claimant is not a party and is prohibited by statute from filing its own Declaration of Readiness. The medical provider would have to be put on notice of the maximum duration dates so that it would have to opportunity to decline to provide further treatment.

Recommendation 11: Labor Code section 4903.5 should be amended to forbid filing a medical or medical-legal lien until the bill is genuinely in dispute.

The statute already contains a prohibition against premature filings but the lien claimants often ignore it. The lien claimants can't prosecute their liens anyway until the case in chief is resolved. What is far more of a problem is the provider that doesn't file a lien at all and then there is no way for the defendant to obtain closure at the DWC District Office.

Recommendation 12: Labor Code section 4903.6 and Rule 10770.5 should be amended to provide consequences for violation that can be effective deterrents to premature filings. Rule 10770.5 already provides for sanctions for filing a lien or Application for Adjudication without a declaration under penalty of perjury or with a false declaration.

Recommendation 13: Enact a statute of limitations, effective prospectively based on date of services to bar any lien unless the service is billed in accordance with regulations and the lien is filed within a defined time following that service.

This is an excellent recommendation. This would force the providers to submit to the jurisdiction of the DWC or have their liens barred by the statute of limitations. If it filed a lien and did not prosecute it timely, the DWC would have the authority to dismiss it.

Recommendation 14: Enact a statute of limitations to bar any lien for service, regardless of date of service, which is not filed within three years of the date of medical service.

This is an excellent recommendation.

Recommendation 15: Eliminate implied liens for medical treatment or medical-legal expenses.

This is an excellent recommendation that would nullify the WCAB decisions that hold that if the provider sends a bill to the claims administrator and it is thereafter not served with a copy of the Compromise and Release, the statute of limitations is tolled until such time that service is effected. It would be even better if the amendment to Labor Code §4904 could be made declaratory of existing law so that it could be applied retroactively. This might be a reasonable interpretation of the existing statute which appears to be limited to EDD liens.

Recommendation 16: Impose automatic dismissal by operation of law for any lien which is not activated for hearing within finite time.

This is an excellent recommendation but might be subject to attack on due process grounds. Currently, the only type of dismissal that does not require notice and an opportunity to be heard is where the applicant requests dismissal of the Application for Adjudication.

Recommendation 17: Allow additional time for medical insurers to file liens for reimbursement of sums paid for covered treatment.

Group health plans and related entities already have six months to file a lien after they become aware that the treatment might have been industrially related.

Recommendation 18: A lien claimant should be required to disclose its relationship to the original provider of goods or services and produce documentation on demand.

Title 8, CCR §10550(d) provides that "if a lien claim is being filed or amended, or if a lien claimant is appearing, the lien claimant shall state whether it is the original owner of the alleged debt or whether it has purchased the alleged debt from the original owner or some subsequent purchaser." The type of documentation to be produced should be clarified. Failure to comply that requires a continuance of a DWC hearing should obligate the lien claimant or representative to reimburse the defendants for the cost of the appearance.

Recommendation 19: A lien representative should be required to provide documentation of the representative's authority upon demand.

This is an excellent recommendation. It is not uncommon to find two lien representatives, each claiming to represent the same lien claimant concerning the same lien.

Recommendation 20: Misrepresentations of ownership of a lien or the authority of a representative should be punished as contempt and should be grounds for dismissal of the lien or for barring the representative from appearing in any proceedings before the Appeals Board.

From a procedural standpoint, it is much easier to award sanctions than to find contempt which requires a quasi-criminal procedure. Furthermore, sanctions allow payment to the adverse party whereas a contempt fine can only be paid into the General Fund. In any event, the prohibited conduct would constitute an indirect contempt which falls under the jurisdiction of the WCAB in San Francisco and could not be adjudicated by a WCJ. Labor Code §4907 empowers the WCAB (Commissioners) to remove the privilege of a representative to appear before the WCAB, after a hearing.

Recommendation 21: Payments in satisfaction of settlement of liens should be made only to the original provider of goods or services unless a bona fide assignment is documented.

This is an excellent recommendation.

Recommendation 22: The Administrative Director should adopt a fee schedule and ground rules for payment of copy services.

This is an excellent recommendation. However, it would not affect services performed before the effective date. (Please see Recommendation 5.)

Recommendation 23: The Form 6, "Notice and Request for Allowance of Lien" should be revised to identify liens for document copying services as well as the grounds for claiming the lien.

This is an excellent recommendation. The more the DWC's forms can conform to the realities of the practice, the fewer ambiguities there will be.

Recommendation 24: Either regulations or statute should be adopted to clearly prescribe the events for which interpreter services are payable.

This is an excellent recommendation. Right now, there is no provision in the Labor Code that specifically imposes liability on the defendant for payment of interpreters' services in connection with medical treatment. Thus, there are no regulations either. Such authorization would require an amendment of the Labor Code unless the WCAB deemed interpreters for treatment to be included under the general provisions of Labor Code §4600. Otherwise, there are already statutes that clearly impose liability on defendants for interpreters at DWC hearings or arbitrations, and in connection with depositions and medical-legal exams.

In 1998, Assembly Bill 236 was passed by the Legislature but was vetoed by the Governor. This bill would have amended what is now Labor Code §4600(f) to include examinations by treating physicians. The veto was based on the fear that medical providers would bill for services performed by their office staff in the absence of a requirement that an independent interpreting service be used.

In addition to prescribing events for which interpreter services are payable, the manner in which those services are to be provided should also be the subject of regulation. It is not cost effective to allow a single interpreter to bill a minimum amount for every type of medical treatment service, whether an allowable event or not. In many cases, the bill of the interpreter

will exceed that of the doctor. Consideration should be given to adding a percentage onto the fee schedule allowance for the service to defray the cost of utilizing the doctor's office staff or to utilize telephonic interpreting services or to apportion the cost of a single interpreter assigned to the same doctor during the same day between the insurers for the patients seen on that day who need an interpreter in the particular language.

Recommendation 25: Either the interpreters' fee schedule should provide for apportioned billing when an interpreter serves multiple cases concurrently, or the WCAB should contract for interpreters to attend hearings and proportionately bill the defendants in each in which they participate.

This is an excellent recommendation.

Recommendation 26: The Administrative Director should amend the fee schedule for interpreter services to promote uniformity and to make the fees generally commensurate with the fair market value of the services.

The existing fee schedule (which does not apply to interpreting for treatment because there is no such statutory authorization) provides for payment at the fee schedule or the "market rate" whichever is greater. For Spanish language interpreters, the fair market value should be no more than the Superior Court interpreters' fee schedule. The market rate should only apply to exotic languages. Otherwise, there is no point of having a fee schedule if the services would always be payable at the higher market rate if the interpreter merely has to show that he/she was recently paid in excess of the fee schedule. Also, there is no reason why an interpreter should be paid more for a conference in a workers' compensation case than interpreting in a criminal trial in the Superior Court.

Recommendation 27: One or more independent organizations should be identified whose accreditation can serve as an alternative to SPB certification for medical examination and administrative hearing interpreters.

If the State Personnel Board doesn't have sufficient funding to conduct interpreter testing and certification, it may be difficult to find the funding to monitor and pay an independent organization to devise a test and do the same thing. A better solution might be to adequately fund the SPB by charging applicants for certification a fee that would cover the cost of administering the test.

Recommendation 28: The subjects of liens should be monitored, and the subjects that arise most frequently should be considered as candidates for improved guidance by the medical treatment utilization schedule and/or applicable fee schedules.

This is an excellent recommendation.

Recommendation 29: Liens by frequent filers that state incorrect lien type or make other material misrepresentations should be subject to substantial penalties, ranging from mandatory sanctions to dismissal with prejudice for repeat violations.

This is an excellent recommendation. However, there would be a significant problem with enforcement unless the defendants were willing to identify the errors in the lien form so that consequences could be applied. The DWC would not have sufficient staff to do this.

Recommendation 30: Lien claimants should be required to use EAMS Uniform Assigned Names (UANs), and until UANs are assigned, lien claimants should be required to use correct legal names.

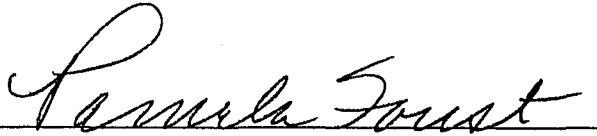
This is also an excellent recommendation but there is again the problem of identifying misrepresentations which the DWC would probably not have the manpower to do. Therefore, the defendants would have to identify incorrect legal names and there would have to be consequences for such inaccuracies.

DATED: January 3, 2011

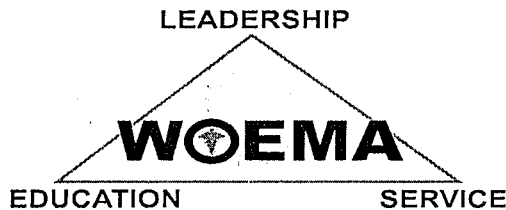
Respectfully submitted,

ZENITH INSURANCE COMPANY

By:

A handwritten signature in cursive script, appearing to read "Pamela Foust", written over a horizontal line.

PAMELA FOUST



Western Occupational & Environmental Medical Association

A Component Society of the American College of Occupational and Environmental Medicine

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January 3, 2011

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Commission on Health and Safety and Workers' Compensation
California Department of Industrial Relations
1515 Clay Street, Room 901
Oakland, CA 94612

RE: Draft Liens Report

Dear Commissioners:

The Western Occupational and Environmental Medical Association (WOEMA) appreciates the opportunity to comment on the Draft Liens Report. Many of WOEMA's member physicians serve as Primary Treating Physicians, and they are committed to delivering appropriate, high-quality care to California's injured workers.

As the report makes plain, the volume of medical liens now being filed is untenable. One quarter of all Workers' Compensation medical dollars are now in legal dispute; in Los Angeles alone, the backlog of cases is 800,000 and climbing. We agree that the liens process itself is deeply dysfunctional. However, we also believe that much of the lien growth may be symptomatic of other flaws in the system, such as the lack of an impartial bill review process, timely treatment authorization, and an efficient process for resolving disputes.

The proposed fixes to the liens process seem mostly appropriate. Claimants should act within a clear and reasonable statute of limitations, and filings should meet standards for accuracy, transparency, and completeness. In addition, we believe that electronic filing should be encouraged, perhaps through offering more expeditious review or waiver of the prospective filing fee.

Here are WOEMA's comments on the specific report recommendations, with other comments added at the end:

Recommendation 1: Reinstate a filing fee for medical and medical-legal liens.

WOEMA believes this issue needs more study, and would support only if this provision were tied to other recommendations to guarantee reimbursement of the filing fee if the Claim-in-Chief were to prevail.

Recommendation 2: Require frequent lien filers to file their liens electronically.

WOEMA supports.

Recommendation 3: Prohibit filing of amended liens prior to Declaration of Readiness.

WOEMA supports.

Recommendation 4: Until the volume of liens is substantially reduced by other measures such as recommended in this report, equip the WCAB District Office with sufficient resources to meet workloads.

WOEMA supports.

Recommendation 5: Adopt medical fee schedules to cover those services that are often disputed due to gaps or ambiguities in the existing fee schedules.

WOEMA supports, and stands ready to work with CHSWC and DWC to craft fee schedules for demonstrably valuable and widely accepted services commonly provided by primary care Occupational Medicine physicians not currently reimbursed under OMFS, including administrative services that are often lumped under the 99080 code.

Recommendation 6: Establish an administrative system for fee schedule determinations, subject to limited judicial review.

WOEMA believes that this recommendation needs further clarification, but would certainly support expedited billing and payment mechanisms that were more transparent, timely, and user-friendly.

Recommendation 7: The boundaries of MPN control over medical treatment should be more clearly defined to minimize the potential for disputes over rights to select medical providers.

WOEMA supports. WOEMA stands ready to work with CHSWC and DWC to design pilot projects to explore better ways to empower MPNs to improve medical quality, with appropriately designed incentives.

Recommendation 8: Disputes over assertions of MPN control over medical treatment should be brought to adjudication promptly.

WOEMA disagrees that medical control over treatment deserves another level of adjudication. We

certainly agree that MPNs should be given additional incentives and tools to resolve disputes over medical control, as part of a broader initiative to improve medical quality. We believe that MPNs could play a valuable "customer service" role in resolving patient complaints. We also believe that the QMR mechanism might be strengthened to provide timely resolution of many complaints. WOEMA favors processes to provide a quick determination of which treater is authorized so that further decisions can be made promptly about treatment recommendations.

Recommendation 9: Sanctions should be imposed on providers and claims administrators alike for repeated patterns of incorrectly asserting or denying the status of an authorized medical provider.

WOEMA would probably support this in concept, but we need clarification.

Recommendation 10: Consider establishing a maximum duration for treatment that can be claimed by lien in the absence of a Declaration of Readiness by the worker to seek authorization for the worker's chosen provider.

WOEMA is unclear about this. This solution might be supplanted by expedited processes for determining causation and medical necessity.

Recommendation 11: Labor Code section 4903.6 should be amended to forbid filing a medical or medical-legal lien until the bill is genuinely in dispute.

WOEMA supports in part. We believe that other changes to Labor Code section 4903.6 might be needed, to protect the billings for authorized services in cases where the claimant has filed an Application for Adjudication with the WCAB.

Recommendation 12: Labor Code section 4903.6 and Rule 10770.5 should be amended to provide consequences for violation that can be effective deterrents to premature filings.

WOEMA supports in part. We believe that with fairer and more expeditious processes, the rate of inappropriate lien filings should decreased substantially.

Recommendation 13: Enact a statute of limitations, effective prospectively based on date of services to bar any lien unless the service is billed in accordance with regulations and the lien is filed within a defined time following that service.

WOEMA supports in part, but believes that this recommendation should be accompanied by transparent, user-friendly, and timely public notification about WCAB filings. We are not clear how this Recommendation is to be reconciled with Recommendation 17, below.

Recommendation 14: Enact a statute of limitations to bar any lien for service, regardless of date of service, which is not filed within three years of the date of medical service.

WOEMA supports in part, but believes that this recommendation should be accompanied by

transparent, user-friendly, and timely public notification about WCAB filings. We are not clear how this Recommendation is to be reconciled with Recommendation 17, below.

Recommendation 15: Eliminate implied liens for medical treatment or medical-legal expenses.

No opinion.

Recommendation 16: Impose automatic dismissal by operation of law for any lien which is not activated for hearing within finite time.

WOEMA supports.

Recommendation 17: Allow additional time for medical insurers to file liens for reimbursement of sums paid for covered treatment.

WOEMA supports in concept, and would favor an even longer period, perhaps with language more consistent with the Statute of limitations for Federal Workers' Compensation. However, we are unclear how this recommendation should be reconciled with Recommendations 13 and 14 above.

Recommendation 18: A lien claimant should be required to disclose its relationship to the original provider of goods or services and produce documentation on demand.

WOEMA supports.

Recommendation 19: A lien representative should be required to provide documentation of the representative's authority upon demand.

WOEMA supports.

Recommendation 20: Misrepresentations of ownership of a lien or the authority of a representative should be punished as contempt and should be grounds for dismissal of the lien or for barring the representative from appearing in any proceedings before the Appeals Board.

WOEMA supports.

Recommendation 21: Payments in satisfaction or settlement of liens should be made only to the original provider of goods or services unless a bona fide assignment is documented.

WOEMA supports.

Recommendation 22: The Administrative Director should adopt a fee schedule and ground rules for payment of copy services.

WOEMA supports.

Recommendation 23: The Form 6, "Notice and Request for Allowance of Lien," should be revised to identify liens for document copying services as well as the grounds for claiming the lien.

WOEMA supports.

Recommendation 24: Either regulation or statute should be adopted to clearly prescribe the events for which interpreter services are payable.

WOEMA supports, and would note that the current fee schedule (use of Modifier 93) to pay medical providers extra when caring for workers who do not speak English often does not fairly compensate for the extra time and difficulty required.

Recommendation 25: Either the interpreters' fee schedule should provide for apportioned billing when an interpreter serves multiple cases concurrently, or the WCAB should contract for interpreters to attend hearings and proportionately bill the defendants in each in which they participate.

WOEMA does not have an opinion about this, but would not likely oppose.

Recommendation 26: The Administrative Director should amend the fee schedule for interpreter services to promote uniformity and to make the fees generally commensurate with the fair market value of the services.

WOEMA supports.

Recommendation 27: One or more independent organizations should be identified whose accreditation can serve as an alternative to SPB certification for medical examination and administrative hearing interpreters.

No opinion.

Recommendation 28: The subjects of liens should be monitored, and the subjects that arise most frequently should be considered as candidates for improved guidance by the medical treatment utilization schedule and/or applicable fee schedules.

WOEMA supports this strongly, and believes that CHSWC should take an even stronger role in monitoring the epidemiology of medical care for injured workers in California.

Recommendation 29: Liens by frequent filers that state incorrect lien type or make other material misrepresentations should be subject to substantial penalties, ranging from mandatory sanctions to dismissal with prejudice for repeat violations.

WOEMA supports.

Recommendation 30: Lien claimants should be required to use EAMS Uniform Assigned Names (UANs), and until UANs are assigned, lien claimants should be required to use correct legal names.

WOEMA supports.

In addition, we believe the proposed \$100 filing fee would be problematic. The fee may indeed deter some spurious filings. But it may also encourage routine underpayment of bills by creating a modest but tangible disincentive for providers to file. At the very least, physicians who prevail on their lien claims should recover their filing fee. Even so, it unclear to us that DWC currently has the capacity to collect and process the individual fees, and worry that the fees would create more "process" in the name of reducing it.

Finally, WOEMA would urge DWC and CHSWC to consider additional improvements "upstream" of the liens process. These would include:

- Offer a binding, impartial dispute resolution process within DWC. At its simplest, the process could be conducted like baseball-style arbitration, in which the provider and payor each submit a proposed settlement with the reviewing panel choosing either one or the other.
- Consider alternative forms of bill review. Currently, payers perform their own bill review or contract for it with a third party. These arrangements have the inherent potential to mix financial considerations into medical decision-making. In a better system, the relationship would be more "arms length." Admittedly, this would be more of long-term goal than a short-term fix.
- Fix the Official Medical Fee Schedule. OMFS is obsolete, arcane and incomplete. Not all procedures are covered, which creates wholly unnecessary ambiguity around appropriate billing and payment.
- Consider creating a drug formulary with a fee schedule for compound medications as a way of standardizing the process and decreasing potential for disputes.

Again, WOEMA appreciates the opportunity to comment, and we look forward to exploring solutions with CHSWC, the Administration, and fellow stakeholders.

Sincerely,



Paul Papanek, MD, MPH, FACOEM
President, WOEMA

Response/comment for Draft Liens Report

Stephen Schneider [StephenSchneider@getrecords.com]

Sent: Monday, January 03, 2011 11:06 PM**To:** CHSWC@DIR

To: Commission on Health and Safety and Workers' Compensation**Regarding:** Draft Liens Report for public comment**From:** Warren Schneider, Attorney At Law, President of Med-Legal, Inc.
Stephen Schneider, CEO of Med-Legal, Inc.

We would like to submit some comments and suggestions for improving the handling of liens in the California workers compensation system.

Lien Filing Fees are specifically disallowed by the Labor Code:

Labor Code 5811(a) states: No fees shall be charged by the clerk of any court for the performance of any official service required by this division, except for the docketing of awards as judgments and for certified copies of transcripts thereof.

While we are in support of a filing fee – as long as there is a corresponding Lien Answer filing fee – it would seem that this controversial regulation is specifically disallowed by the legislature in Labor Code 5811.

With that said, if the DWC were to proceed with a lien filing fee in the face of LC 5811 (and the constitutional “unencumbered” basis for the workers compensation system) we propose the following:

Lien Answer filing fee:

A filing fee for liens addresses one side of the lien problem (frivolous lien claims) but it fails to address the frivolous objections, delays and unnecessary hearings caused by the defense. Just as is the practice in Superior courts, an Answer filing fee should be part of any new regulations regarding lien filing fees.

It would be a denial of equal protection to require a filing fee for a lien based upon services procured by the applicant and not require a responsive filing fee by the defendant.

The regulation should allow the prevailing party to have their filing fees paid by the “loser” so now BOTH sides will make every effort to keep a particular invoice from getting filed as a lien in the first place. This makes BOTH the lien claimant and the defendant pay close attention to the facts and issues surrounding the contested charges, and forces them BOTH to invest cash into their position before using up the WCAB's valuable time.

Limitations on filing a Lien:

Lien claimants would be required to attach some basic points and authorities establishing the basis of the lien, and what efforts have been made to resolve the lien informally. Lien claimants would not be

required to submit points and authorities on the issues raised by the defendant until the defendant files the Lien Answer and establishes those issues before the WCAB. Lien claimants would have the opportunity to attach a petition for immediate order for payment if the defendant failed to object timely and/or pay the uncontested amounts. In that situation, the facts, arguments and full points and authorities should be included in the petition and filed with the lien. Such Petitions should be considered by the WCJ within 60 days and Orders issued accordingly.

Limitations on filing a Lien Answer:

A big part of the lien problem – at least for legitimate liens – is the defense fails to negotiate timely and settle the issues in good faith. LC 4622 and Regulation 9794 already establishes that the defendant must pay amounts uncontested timely and serve written objections on the lien claimant and all parties explaining why the remaining balance is not being paid. Those objections must not be “form objections” and must be specific to the contested charges. A general denial is not allowed. Therefore, any Lien Answer submitted for filing must, in addition to the payment of the filing fee, include evidence that uncontested amounts were paid timely and include a proof of service of the timely written objections on the Lien Claimant and other parties. That proof of service must show timely service of the objections in accordance with LC 4622 and Regulation 9794 (be specific and not a form letter, etc.), and a copy of the objection correspondence must be attached to the Lien Answer filing establishing the issues before the WCAB.

If the defendant fails to pay uncontested amounts timely or fails to object timely and appropriately the Lien Answer filing should be rejected and the lien be automatically ordered paid in full, plus penalties and interest, plus the reimbursement of the lien filing fee to the lien claimant. There are several cases supporting the position that the defendant waives their right to object if they fail to object timely and pay uncontested amounts. By writing into the Regulation that the Lien Answer filing must be rejected by the DWC if the defendant failed to take the appropriate steps would remove the necessity of a decision from the WCJ, reducing the risk of a petition for reconsideration.

Only the issues raised on the Lien Answer may be heard:

Oftentimes a defendant may serve weak or boilerplate objections timely, then raise additional objections later, after they have finally paid serious attention to the lien. This doesn't usually occur until AFTER the case in chief is settled. This practice contributes to the lien problem as a whole by delaying any real effort to settle the lien until a lien hearing has been set.

Similar to the civil courts, new Regulations should accompany any filing fee regulations establishing that only issues raised timely on the Lien Answer filing may be ruled upon by the WCJ. In other words, once the lien is filed and the Lien Answer is filed, the issues are locked and no further issues can be raised. This procedure will force the parties to legitimately negotiate the invoice/charges before the lien is ever filed. It will also make litigating the liens before the WCAB much more efficient.

Response to Answer:

Regulations must be passed that allow the Lien Claimant to file a Response to the defendant's Answer within 20 days of the filing of said Answer. The arguments and points and authorities contained in the defendant's Answer and the Lien Claimant's Response should be adequate for the WCJ to make a ruling on the lien without testimony, without a court reporter, and without using up valuable courtroom time.

Automatic payment orders when Answer not filed:

Any lien properly filed should automatically be ordered paid if the defendant failed to file an Answer within 20 days of notice of the lien filing. A big part of the lien problem now is the parties (and WCJs) fail to take the liens seriously. The filing fees and automatic payment orders will force the defendant to handle the lien legitimately or risk paying not just the lien, but penalties, interest and the lien filing fee.

If the defendant paid the uncontested amounts timely, served their objections timely and legitimately, answered the phone when the lien claimant called to settle the issues raised, then filing a Lien Answer timely shouldn't be a burden. The issues will be fresh in their mind and typed correspondence outlining the arguments, points and authorities already in the file.

Timely Orders by WCJs:

Inaction by the WCJs is a big part of the current lien problem, especially in Southern California. Forcing the lien claimant and defendant to follow the new procedures outlined here and pay significant filing fees will be burdensome if WCJs continue to ignore liens until after the case in chief is completed, fail to issue orders in response to valid petitions, and require several frivolous appearances by the parties before decisions are made. It is the WCJ's continued pressure to "go out there and settle this" regardless of the merits of either side that contributes to frivolous lien filings, and frivolous delays and non-payment by the defense. Frivolous liens become profitable because everybody knows the WCJ will force a settlement out of the defense. And the defendant can threaten a small lien claimant with multiple appearances if they don't take a significant reduction on their lien during negotiations. With the system we have proposed here the parties will have submitted the issues in writing with points and authorities and the WCJ should have little trouble making a decision on the merits of the submissions. No testimony would be necessary. The new regulations should require the WCJs to issue orders timely after the Lien, Lien Answer, and Lien Response have all been successfully filed.

This process might seem burdensome on the WCJs at first, but consider that the filing fee and strict Regulations will all but eliminate frivolous lien filings, and the Answer filing fee will all but eliminate frivolous objections and unnecessary delays by the defendant. What would be left would be real issues that need a decision, and these decisions could be made quickly by the WCJ without a hearing or courtroom time. Arguments for both sides would be well documented in EAMS as part of the filings.

By getting a quick response from the WCAB the filings fees will not be so burdensome on the parties. If the liens continue to sit at the WCAB for years before a decision is made the accumulated filing fees for both parties will become an impediment to doing business within the system. All the parties involved – including the WCJs – must do their part to solve this lien problem in a way we can all live with.

Effect of these proposed changes:

What we would have if the changes proposed here were implemented is a system where a lien claimant must pay a significant fee to get an order for payment on unpaid charges related to services rendered, and risk paying the defendant's fees if those charges are without merit. That is a significant deterrent to filing frivolous liens, especially for smaller lien claimants that take up a significant volume of the liens filed today.

The defendant's risk is similar. The penalty for failing to properly respond to a lien would now include

both filing fees, in addition to automatic penalties and interest on the lien. This will put significant pressure on defendants to pay attention to the invoices they receive and handle them timely and in good faith – so they don't have to get filed as liens. At the same time, the defendant has a powerful weapon to confront frivolous lien filers, extracting from them the Answer filing fees and forcing them to pay the lien filing fees on their ultimately denied lien. This weapon should help savvy defendants drive frivolous lien claimants from the system.

Most important is that the proposed changes are fair – both sides are forced to pay equally, and jump through similar legal hoops and deadlines.

A system as we have just proposed would cause everybody in the system – lien claimant, defendant and WCJ to document the issues, provide critical thinking and authority on the issues, and otherwise handle the lien legitimately instead of trying to put it off, avoid dealing with it, and letting the huge lien backlogs build up.

Proposed Procedures – Summary

To summarize the proposed changes, the following new or edited Regulations would be required:

1. A Lien Filing Fee would be established
2. Lien Filing procedures would be established that include basic points and authorities proving up the lien as a requirement for the filing.
3. A Lien Answer Fee would be established
4. Lien Answer procedures would be established requiring the defendant to object in accordance with LC 4622 and Reg 9794 (no frivolous or form objections) and pay un-contested amounts timely before being allowed to file an Answer. A general denial is not allowed. Failure by the defendant to follow these procedures and timelines and attach proof of the steps will cause the Answer filing to be rejected. Answers must be filed timely after the lien filing, so Answers filed more than 20 days from the date of the Lien Filing will be rejected.
5. Failure to file an Answer would cause the lien to immediately be ordered paid, plus penalties, interest and reimbursement of the Lien Filing fee.
6. Lien Claimant would be given 20 days to file a Response to the Answer, and provide points and authorities supporting the lien in light of the defendant's arguments.
7. The WCAB would be required to issue an order regarding the lien 60 days after the filing of the Lien, Answer and Response. No testimony would be taken unless one of the parties requested a hearing and filed a Declaration of Readiness on the lien. Lien filings will no longer be delayed until the case in chief is completed.
8. Prevailing parties are reimbursed for their filing fees by the loser.

Draft Lien Report for Public Comment- INTERPRETER ISSUES

Lorena Ortiz Schneider [futbollos@mac.com]

Sent: Tuesday, January 04, 2011 2:55 PM**To:** CHSWC@DIR

To Whom it May Concern,

I was hoping to make it to Oakland tomorrow, but instead offer the following comments for the Commission to consider.

As a brief introduction, I am Lorena Ortiz Schneider, owner of Ortiz Schneider Interpreting & Translation in Santa Barbara California. I have a Master's Degree in Translation & Conference Interpretation from the Monterey Institute of International Studies '92, an an Administrative Hearing Certified Interpreter in the State of California, am Certified by the American Translators Association, the Translators & Interpreters Guild and have been working in the Workers' Compensation community for almost 20 years. I speak 4 languages and am bi-cultural, having lived in various Spanish speaking countries throughout my life, not to mention the rest of my experience abroad.

I echo the view points and opinions of my colleagues, especially those of Mr. Altman, who sent you a comment via e-mail last month. Specifically:

- The WCAB wouldn't find itself in its current position, overburdened by liens, if the insurance carriers would honor the Labor Code and Administrative Rules and pay for the interpreting services therein provided for in a timely fashion. I too, receive countless groundless objections to my services as well as conflicting information often from the same insurance company. From the outside looking in, it would appear that the adjusters are often fickle when it comes to deciding on which bills for services get paid and which receive an objection notice. Enforcement would put an end to this practice.
- The only time I file a lien is when all other methods to elicit payment have failed. In essence, the only way to get heard is by filing a lien (often in conjunction with a DOR). In 90% of the cases, I am able to settle my lien without having to go to trial. In the other 10% of the cases, I have prevailed, even upon recon. Ergo, the insurance companies would not only save the WCAB a lot of time and frustration but also save money if they were to follow the regulations as stipulated and pay for legitimate services in a timely manner. It is amazing the amount of money they are willing to spend on attorney's fees in order to fight an interpreting lien of a few hundred dollars.
- It is sheer hypocrisy to expect interpreting agencies and independent contractors practicing their chosen profession, interpreting, to pro-rate their fees when interpreting for multiple clients in any given day. This is not the way the system is set up. The defense attorneys surely do not pro-rate their fees in the same manner as being suggested nor do the insurance companies pro-rate their fees every time they underwrite a new subscriber. Furthermore, interpreters and interpreting agencies who contract with them are entrepreneurial in nature and not employees. Does the WCAB want to hire interpreters in order to save the insurance companies money? This would be simply passing on the cost to the State, which it can obviously ill-afford.
- I will quote Mr. Altman: " To alleviate a lot of unnecessary litigation, the language contained in Labor Code §4600 and which is used in AR 9795.3 (a) 1. should be changed and written as "A reasonable and necessary examination by a physician to which an injured employee submits"." (Please refer to Mr. Altman's e-mail for the full text). It is a known fact that were it not for interpreters' assistance during

medical follow-up appointments, the doctors would be unable to write their reports, treat or cure the effects of the applicant's injuries and the system as we know it would flail. Communication is a fundamental need and is deemed so by the very existence of the interpreting profession in the medical setting, especially as regards the Workers' Comp system. One need not look any further than at the decisions that have been made in favor of the necessity of interpreters in the medical setting. Too much is at stake to permit non-professionals (such as "bilingual" medical personnel) to do our job. We are professionals with credentials, the need for interpreters is embodied in the Labor Code, carriers pay for our services in the medical setting. In fact I have several Market Rate agreements with certain carriers to provide services in the "treatment" setting. To claim that we interpreters are the problem is highly disingenuous.

- As for amending the fee schedule for interpreting services, the code already provides for a minimum fee OR a market rate "whichever is greater." This is in place given the diversity of economies and availability of certified interpreters throughout the state. Each carrier and interpreter should be able to go through a logical process, as provided, and arrive at a mutually beneficial rate should the minimum be insufficient (which in my neck of the woods it is).

- As for brining on independent organizations to provide alternative accreditation, I would caution that the Commission tread lightly and offer said opportunity to tried-and-true institutions such as the American Translators Association and the Monterrey Institute of International Studies, or even Georgetown University, all of which specialize in the field and have the knowledge of what it takes to be a competent interpreter and can uphold the strict standards on which our profession are based. To the contrary, we will end up with a watered down profession, filled with unskilled workers who will drive up litigation costs because of their mistakes.

- Should the Commission entertain changes that will affect the interpreting community, I would request the Commission invite a State Certified Interpreter to be a member of the panel making decisions.

Thank you for taking the time to read my comments. I wish you all the best in this serious and daunting undertaking.

Sincerely,

Lorena Ortiz Schneider

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January 3, 2011

To: The Commission on Health and Safety and Workers' Compensation, Christine Baker and Judge Lachlan Taylor

From: David D. Robin
Attorney at Law

Re: Public Comment on Draft Liens Report

Ladies and Gentlemen:

Thank you for allowing me to provide written commentary on the draft "Liens Report". I am a California licensed attorney of thirty years, all in the practice of Workers' Compensation with the majority of that time representing health plans as lien claimants before the WCAB.

First, let me take the time to compliment Judge Taylor for having taken on the unenviable but necessary task of addressing the current lien issues from an objective standpoint utilizing as much hard data as is available and, while taking into account the overwhelming number of anecdotal stories of abuse by lien claimants and payors alike, attempting to make some sense of how to work ourselves out of the current backlog of liens that is currently choking the system. More important, the proposals outlined in the thirty (30) recommendations providing some sort of groundwork to decrease the volume of liens filed in the future in part by directing provider and payor to work more closely together prior to the filing of a lien and involving the WCAB.

On behalf of the health insurance plans doing business in California, I am grateful to the Commission that they have recognized the inherent differences between the services they provide and those of direct providers of medical services [please see "Medical Insurers Require Exception" pages 38-39 and summarized in Recommendation 17]. This draft leaves it to policymakers in the future to determine the exact form of the longer time limitations for health insurance plans. I strongly urge the Commission to include representative(s) from the health insurance industry when formulating the definitive language of time limitations so that the health insurance plans will have the continuing opportunity to participate in the reimbursement process.

As an initial suggestion, this issue has been previously addressed by policy makers which resulted in Labor Code Section 4903.5. At the time it was not appreciated that the language incorporated would later be construed as to fully encompassing almost all medical providers.

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The suggestion that the statute remain intact but be narrowly construed to include only

- Health care service plan.
- Group disability insurer.
- Employee benefit plan.

is a good one. I would further submit that this exception be extended to union trust funds, other entities governed by Knox Keene, the Veteran's Administration, MediCare and Medi-Cal, along with public and private hospitals who are legally obligated to provide care to the indigent and otherwise receive no payment for services from any third party.

I have previously recommended to the Commission that the liens filed by the health insurance industry be construed as being filed pursuant to Labor Code Section 4903.1 rather than Section 4903(b). Section 4903.1(a) defines the groups listed above and differentiates them from direct providers of medical services. The important distinction lies within the remainder of 4903.1 wherein liens of the health insurance industry are subject to involuntary reduction by the Gregory formula if there is a bona fide dispute over the need for treatment arising out of workers' compensation injury or illness. By this very means the parties to the workers' compensation claim have the ability, if exercised timely, to resolve these liens without taking up continued court time with lien trials.

In this same vein, I believe that these types of liens should be excluded from the re-enactment of the proposed lien filing fee under Labor Code Section 4903.05. The goal of the reinstatement of the filing fee has been clearly stated in Recommendation 1 – to deter the filing of liens. As described in the first 10 pages of the draft report, there is an ever increasing number of liens being filed and only the reinstatement of the filing fee will bring this number under control. To briefly summarize the problem, there has been a proliferation of lien filings by providers of questionable treatment, including undocumented treatment, unauthorized treatment outside of the employer's MPN, grossly overindulgent and unnecessary treatment and the sale or factoring of either the treatment liens to 3rd parties or, even worse, the sale of balance billing to 3rd parties by providers who have already received payment at OMFS. It is the stated goal of the WCAB to reduce the number of liens.

To borrow from the general workers' compensation vocabulary, these problems have not been caused, aggravated or accelerated by health insurance plans. On an annual basis, the number of liens filed in general by health insurance plans have remained relatively constant. There is a correlation between the number of lives insured and the number of liens filed by health insurance plans. The ratio has been approximately 0.75% of the insureds who claim workers' compensation benefits by filing an application for adjudication of claim with the WCAB have treated or had treatment paid by health insurance plans for the alleged condition. The more lives that are insured, the more corresponding potential lien claims will be filed pursuant to §4903.1(a)(1)&(2). As we are in an extended economic downturn with many employers decreasing benefits to their employees, the amount of liens filed by health insurance plans should continue to decrease as it has done in the last two years. Getting back to the point, health insurance plans are not causing an increase in the number of liens being filed with the WCAB.

Re: Public Comment on Draft Liens Report

January 3, 2011

Page 3

Rarely is there an issue over the validity of the treatment provided – the treatment is no different than that provided to patients on a nonindustrial basis. For those health insurance plans who pay for treatment rather than provide it directly, the bills are subject to reduction to contract rate either at or near OMFS and certainly less than usual and customary RVS which is generally the billed amount. The real issue is whether or not the treatment relates to an industrial injury or not.

Under this scenario I just cannot see how the health insurance plan liens should be subjected to the same scrutiny as the direct providers of medical services liens filed pursuant to §4903(b). I hope that you agree and thereby codify that the liens of health insurance plans filed pursuant to §4903.1(a)(1)&(2) are different from provider liens and are not subject to the lien filing fee statute proposed by §4903.05.

Thank you very much for your attention to these comments.

Respectfully yours,

David D. Robin
Attorney at Law

david.robin@the4600group.com

Response to Draft Line Report Dated 12/16/2010

Dan Jakle [djakle@arslegal.com]

Sent: Tuesday, January 04, 2011 10:01 PM**To:** CHSWC@DIR**Cc:** Stephen Schneider [StephenSchneider@getrecords.com]

The following response is directed to the Commission on Health and Safety and Workers Compensation

I appreciate the thought and study that has gone into this document. However, I suggest that perhaps the legislation is already in place if we only put it into action.

This document appears to have been drawn from the perspective of the carrier without much input from the lien claimants as a whole. The idea of a \$100 filing fee is one more item with the appearance of "it's the lien claimants fault that there are so many liens clogging up the system". Why not charge the carrier/defense respondent \$100 and waive the \$100 on the successful party if payment on the lien is made? Would the money go into the general fund or go to help applicants in workers comp. I submit it would not help the applicants.

I represent a copy service that, due to the size of our company files a great number of liens each month. However, 75% of them are paid without objection, 20% of them are negotiated to a settlement acceptable to both parties. This provides a great body of evidence that our liens are reasonable. Only 5% of our invoices have to be put through the lien process and fought in lien conferences and trials.

Problem: We submit an invoice, it is objected to as unreasonable. We offer to negotiate with the carrier to which they steadfastly refuse. Their refusal forces us to go to a lien conference costing us more expense to support out lien. Then at the line conference after it has cost us more to fight the lien, the carrier will offer what we had offered before the line conference or trial. Solution: Allow us to be paid sanctions and penalties for this obviously frivolous action.

Problem: The carrier will pay our full invoice of a particular order and then refuse another invoice (different location) from the same order complaining that our prices are too high. Solution: Allow us to get sanctions and penalties for this obviously frivolous action.

We are confronted with the objection that our records are duplicative when the defense has offered to provide the records. However, the carrier does not offer a certificate from the custodian that the records are true and complete under penalty of perjury and on this issue of duplicative records the board has ruled on recon that the applicant has the right to get his own records. On the issue of reasonableness of our prices the board has also ruled in our favor as well.

We suggest that the invoice be the instrument on which to be paid. That it be treated as a defacto lien and be paid promptly if there is no timely objection and that the carrier not be allowed to keep submitting the same warn out previously defeated objections. We would then only file a lien if there is some new substantive issue.

Regards,



Dan R. Jakle
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